REPORT OF THE ACCOUNTABILITY TASK FORCE

January, 1994

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The contribution made by each person listed here is gratefully acknowledged.

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EXECUTIVE SUMMARY

The Accountability Task Force was established by the Department of Environment, Health, and Natural Resources to propose a public health accountability system. Some of the parameters of this accountability system were defined in House Bill 183 (1991), which directed DEHNR to "implement a monitoring and evaluation program to measure local health department progress in applying health outcome standards and achieving health outcome objectives established by the Commission for Health Services...and to provide assistance to local health departments that are having difficulty meeting objectives." The members of the Accountability Task Force have been drawn from both the local and the state level, and we bring to our task training in a range of public health disciplines. The report of the Accountability Task Force describes the accountability system we propose for consideration. It describes legislative mandates for accountability. It discusses the benefits to be gained from implementing a carefully considered accountability system. It proposes an accountability tool, an accountability process, a means of institutionalizing a system of accountability and a means of integrating measures of accountability into our public health system.

An accurate accountability system will provide a number of benefits. By fairly measuring performance, it will help the public health system enter the era of performance-based management. It will provide members of the legislature, the executive branch and other policy makers with evidence that funds earmarked for health care services are being well spent, that services are being delivered efficiently and that health outcomes are being improved.

A meaningful accountability system will help communities, local agencies and DEHNR health divisions identify areas of high morbidity or mortality anywhere in the public health spectrum. It will also help demonstrate when these problems are attributable to gaps in service provision or systems failures, to holes in the "safety net" public health providers have traditionally tried to provide. An accountability system will fairly identify programs where there appear to be problems in service provision. It should provide statewide data that can be used at the local level to document when a health care facility is inadequate, when a pay scale is too low or when additional staff are needed to accomplish the job at hand. If a problem is

confirmed, the accountability system will allow monitoring of the progress of a corrective action plan and the resolution of the problem.

The accountability system should also be an effective advocacy tool. The accountability system will identify areas where key public health services are lacking because resources are insufficient to provide them. In particular, it should provide a consistent, systematic means of documenting unmet need for health services designated by the legislature as essential. In addition, the effectiveness of the State Health Director as an advocate for public health will be enhanced if the public health community he leads is seen as accepting the principle of accountability and as implementing a meaningful accountability process.

The report of the Accountability Task Force describes a three level accountability system. Level I will consist of a Community Wellness Index, a "snapshot" of fourteen indicators of health status in each community. These indicators will be population-based measures of health outcomes that will address the legislature's emphasis on outcome measures. Examples of most of the Level I indicators are included in the report. Level II measures will add process measures to outcome measures and will attempt to assess the local health department's role in each of the fourteen areas addressed in the Community Wellness Index. Two examples of Level II indicators are included in the report. Level III refers to the monitoring currently being carried out by health divisions. The Accountability Task Force recommends that the various divisions' monitoring activities be coordinated in order to lessen the extent to which they disturb local service provision.

The Accountability Task Force proposes that responsibility for the accountability process should reside in an Office of Accountability, located in the State Health Director's office. We feel this office should receive funding which will be available to help health departments meet specific improvement plan objectives which arise from the accountability process.

The Accountability Task Force proposes that the Office of Accountability should prepare the Community Wellness Index every year; all the data required for these indicators should be

readily available. Level II indicators will be generated every two years, in conjunction with the Community Diagnosis process. The Accountability Task Force envisioned the accountability process and the Community Diagnosis process as two related processes--one which draws from a body of data about public health information to assess at the statewide level the extent to which resources are being used efficiently and effectively to improve a community's health, and one which looks from the community level at needs assessment. The Accountability Task Force feels that the data for these two activities should be integrated; one body of data will be the basis from which the two processes draw their information and formulate their conclusions. To some extent this marries an external assessment process with an internal, self-assessment process.

The report of the Accountability Task Force describes ways to integrate the findings of the accountability process into corrective action plans which can be incorporated into contract addenda. It recommends the streamlining of the current body of regulations which pertain to accountability. It proposes measures which will provide a factual basis for documenting when facilities are inadequate, pay scales too low or staff insufficient for the task at hand.

The proposals of the Accountability Task Force are not intended to be "the final word." They are intended to provide a starting point for discussion, and indeed they have already done so: the report was reviewed in draft form by the Administrative Committee of the North Carolina Association of Local Health Directors and by the Directors of the DEHNR health divisions, and a number of constructive suggestions were made which have been incorporated into this final version. The members of the task force have been gratified by the response the draft version of the report generated in these and other circles. We are sure that additional improvements to the accountability system proposed here will arise as other members of the public health community review the proposals put forth in this report.

I. INTRODUCTION

Accountability in public health--the ability to determine whether resources are being used effectively and efficiently to improve a community's health--is a goal to which everyone seems to subscribe. The proper design of a fair and useful accountability system, however, is a subject about which there is much less agreement.

The members of the Accountability Task Force (ATF) have been charged to propose a public health accountability system. We bring to this task training in a variety of disciplines; we work in several different areas of public health. The task force has balanced representation from the state and local levels. The plan we present here is not put forward as a "state of the art" accountability system; it is intended rather as a starting point for discussion. We believe that discussion of our proposal by members of the public health community will lead to a better design for accountability. We also feel sure that many improvements to any system of accountability will become apparent once an accountability system is implemented.

This report describes the accountability system proposed by the Accountability Task Force. It places this effort to achieve accountability in the context of previous systems of accountability. It describes legislative mandates for accountability. It discusses what we feel may be gained from implementing a carefully considered accountability system. It proposes an accountability tool, an accountability process, a means of institutionalizing a system of accountability and a means of integrating measures of accountability into our public health system.

II. ACCOUNTABILITY: DEFINITION AND CONTEXT

A. Definition

One of the first questions which arose when the ATF met was a definitional one: "who are we talking about being accountable to whom?" The best answer seems to be that accountability exists at several levels. In the broadest sense, there is the accountability of the entire public health system, state and local, to the residents of North Carolina; there is the accountability of the local health departments to their Boards of Health and County Commissioners; there is the accountability of local agencies to the DEHNR agencies which have been charged by the legislative and executive branches to monitor and evaluate local health department progress toward promoting public health; and there is the accountability of the state health officer and the Divisions he heads to the state's elected officials. The accountability system proposed in this report is essentially an attempt to determine whether the resources appropriated to public health are being used in an effective and efficient manner.

B. Context

At the present time, there is no comprehensive DEHNR public health accountability system. A type of departmental accountability system, conducted in the past by the Regional Directors, has not been carried out since these positions were abolished. In any event, that review process was largely a review of local health department policies and did not look at agency performance or the impact of local health department (LHD) activities on health status in the community.

Health divisions do carry out some monitoring activities to attempt to assure that local agencies are complying with federal and state regulations. These activities have several shortcomings: the comprehensiveness of monitoring varies a great deal from division to division; there is no coordination of these individual monitoring efforts into a comprehensive system; and these efforts, focused as they are on assuring compliance with specific regulations, generally do not consider the full range of process and outcome measures of performance that are appropriate components of a comprehensive accountability system.

There now exist two main mandates which describe expectations of the public health system, mandates which are not entirely consistent with one another. In 1984 the Commission for Health Services adopted the "Standards for Mandated Public Health Services" (attached as Appendix 1). In 1991 the General Assembly passed House Bill (HB) 499, "An Act to Establish the Mission and Essential Services of the Public Health System,"(Appendix 2) which directs DEHNR to attempt to assure, within the context of available resources, that a wide range of public health services are available to all citizens of the state. The absence of a meaningful, comprehensive accountability system makes it impossible to determine how adequately these mandates are being met.

In two recent pieces of legislation, the General Assembly has directed DEHNR to enhance its monitoring efforts. HB 183 (1991) directs DEHNR to "implement a monitoring and evaluation program to measure local health department progress in applying health outcome standards and achieving health outcome objectives established by the Commission for Health Services... and to provide assistance to local health departments that are having difficulty meeting objectives."[2] In the most recent legislative session, legislation was passed directing DEHNR to develop a Maternal and Child Health accountability system which will assure that the health care needs of pregnant women, infants and children are met. The legislation authorizes DEHNR to use a wide range of interventions to ensure that improvements, where needed, occur. These may include: "heightened technical assistance; targeting of additional resources; withholding of federal or State funds; administrative changes, including formation of district health departments where appropriate; the appointment of caretaker administrators or public health boards; or any other measure necessary to ensure that the health care needs of pregnant women, infants, and children under age five are being met."[3]

It is clear from these actions of the General Assembly that a majority of legislators feel that public health accountability must be enhanced. In this era of "reinventing government" and performance-based resource allocation, it is the responsibility of the public

health community to demonstrate in a meaningful way the efficacy of public health interventions and the role these interventions play in improving the health status and enhancing the quality of life of North Carolinians.

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[2] HB 183 is attached as Appendix 3

[3] See Appendix 4. Dr. Wolfe, Director of the Division of Maternal and Child Health, has requested that the MCH accountability system mandated above be incorporated into the broader DEHNR system proposed here, and the members of the ATF have agreed to try to do so.

III. BENEFITS OF BETTER ACCOUNTABILITY

An accurate accountability system will provide a number of benefits. As mentioned earlier, by fairly measuring performance, it will help the public health system enter the era of performance-based management. It will provide members of the legislature, the executive branch and other policy makers with evidence that funds earmarked for health care services are being well spent, that services are being delivered efficiently and that health outcomes are being improved. On the other hand, if we are unable to present this evidence, it may become more difficult to convince government policy makers, who are increasingly interested in "reinventing government" principles, that support for public health is justified.

A meaningful accountability system will help communities, local agencies and DEHNR health divisions identify areas of high morbidity or mortality anywhere in the public health spectrum. It will also help demonstrate when these problems are attributable to gaps in service provision or systems failures, to holes in the "safety net" public health providers have traditionally tried to provide. An accountability system will fairly identify programs where there appear to be problems in service provision. It should provide statewide data that can be used at the local level to document when a health care facility is inadequate, when a pay scale is too low or when additional staff are needed to accomplish the job at hand. If a problem is confirmed, the accountability system will allow monitoring of the progress of a corrective action plan and the resolution of the problem.

The accountability system should also be an effective advocacy tool. The accountability system will identify areas where key public health services are lacking because resources are insufficient to provide them. In particular, it should provide a consistent, systematic means of documenting unmet need for health services designated by the legislature as essential. It should provide meaningful evidence to support the argument that increased resources are needed if we are to deliver essential services to all who need them. In addition, the effectiveness of the State Health Director as an advocate for public health will be enhanced if the public health community that he leads is seen as accepting the principle of accountability and as implementing a meaningful accountability process. As a final point, a thoughtful accountability system should

begin to relate delivery of services to improved health outcomes. Although this is, in general, a difficult task to accomplish, it is becoming increasingly crucial: in these times of limited resources, policymakers want to see funding lead to improved health outcomes, not just to delivery of services.

We feel that the accountability system proposed in this report introduces a logical, Department-wide structure to DEHNR accountability activities. It introduces some consistency where at present each Division's accountability activities have existed within their own universe; for this reason it should be more "user-friendly" for local health departments. It will propose increased coordination of Division-specific monitoring activities, which should also be favorable to counties. We have tried in this report to provide our rationale for the steps we propose so that all users of the system will understand why it is designed as it is, what we expect it will do, and what we perceive its limitations to be. Perhaps above all, we have taken great pains to design a system which we believe is fair; we understand that if the system is not perceived as fair, it will not succeed. For example, the General Assembly has mandated that the accountability system measure local health department success in achieving health outcome standards. While we have tried to accomplish this, we recognize that a high county infant mortality rate does not mean that the county health department is deficient. We recognize that health outcome indicators are a very blunt instrument with which to measure health department performance, and as a result we have tried to blend very carefully process measures (such as measures of service delivery) with relevant outcome indicators. We have also recognized that in many areas of public health, insufficient resources prevent local health departments from having a substantial impact on aspects of health status among county residents. We have tried in these instances to document local health department activities and develop a consistent measure of health status and unmet needs. We were aware, during our deliberations, that if DEHNR is not successful in designing and implementing a meaningful accountability system, it is likely that one will be designed <u>for</u> us, one which may not be as sensitive to these fairness issues as the one presented here.

IV. OVERVIEW: A THREE LEVEL ACCOUNTABILITY SYSTEM

In considering the design of an accountability system, the members of the Accountability Task Force identified several key problems. First, we wanted a system that could provide a clear, concise "sound bite" of information, one that would assess outcome measures in a community (as directed by the General Assembly) in a way that is meaningful to the general public. On the other hand, we recognized that a system which is able to measure health department performance accurately will be of necessity somewhat complex. A related issue was the concern that outcome measures may not be very good direct measures of health department performance: as mentioned above, an accountability system that says that a county with a high infant mortality rate must be a county with a poor local health department is not a very fair system. A last issue is the degree to which the accountability system should be a yardstick for communities to measure community-wide health status as opposed to being a system which looks only at health department performance and health department clients. All of the health directors on the Accountability Task Force felt that their charge as health directors extended to the well-being of the community as a whole, and the Task Force decided that it was appropriate to consider community-wide as well as health department-specific measures. In considering both types of measures, we felt it was important to distinguish those areas in which health departments have only limited or negligible impact.

We feel that a useful way to address each of these concerns is to design a stratified accountability system. We propose that Level I of the system will consist of a Community Wellness Index (CWI). The CWI consists of fourteen health status indicators, each of which measures a substantial public health problem. Taken together they will provide a county-specific "snapshot" of public health status. These indicators will be population-based rather than health department-specific measures, so we will be delinking this portion of the system from being any direct measure of LHD performance. By using the CWI as the first level of the accountability system, we will be employing outcome measures of health status (as mandated), we will be providing communities with a "sound bite" measure of health status which may be useful to local public health advocates and we will avoid measuring LHD performance in an inappropriate fashion. The CWI also functions as a public health taxonomy, a template for developing Levels

II and III of the accountability system. The CWI will be discussed more completely in Section VI.

In Level II of the accountability system, each of the areas represented by a CWI indicator is examined in greater detail. Additional outcome indicators are sometimes included and process indicators are also incorporated. Level II indicators are tools to measure how well the community and the health department are addressing the public health needs of the community. Since each of the areas is different, each part of Level II represented a design problem: what were appropriate measures, what data were available at the county level, what key data needs were identified? We have proposed models for some of the Level II indicators most relevant to health department performance. They are described more completely in Section VII.

Level III of the accountability system refers to the program-specific assessment that some of the health divisions are currently carrying out, generally to assure that local agencies are operating in compliance with state and federal regulations. At least in some of the divisions, this represents a labor-intensive, detailed assessment of a large number of indicators, generally process indicators. Although the ATF did not address Level III issues in great detail, we did feel that over time divisions would modify their Level III activities so that Level III monitoring would more directly address issues raised in Level II. Division monitoring activities would then begin to embrace a more comprehensive concept of assessment and assurance than they generally do at present. The members of the ATF also felt that the comprehensive monitoring activities of all the health divisions should be integrated: a three year health department calendar cycle should be established and each county should have a designated period (perhaps two weeks long) during which monitoring could occur. Exceptions would only be allowed in instances where federal or state regulations required more frequent monitoring. ATF members felt that this integration of monitoring will prove more efficient, particularly for local agencies, than current practice. Lastly, Accountability Task Force members felt that agencies which demonstrate excellent performance in a given Level II indicator should be exempted from Level III monitoring in that area, except as required by federal or state statute or regulation.

V. COMPATIBILITY WITH THE COMMUNITY DIAGNOSIS PROCESS

During Accountability Task Force deliberations, we realized that many, although not all, of the data we want to analyze are included in the community diagnosis process. Task Force members feel that the accountability process and the community diagnosis process are complementary; one represents an analysis conducted at the state level of community health status and public health activities, the other represents a self-assessment at the community level of health status and service provision. Task Force members felt that the data relevant to each of the two processes should be integrated into one body of data. These data can then be used for the dual purposes of accountability and community diagnosis; the two processes should be integrated to the fullest extent possible. To promote this integration, the definitions of the indicators used in the two processes should be made as consistent as possible; the data used should cover the same years and Level II accountability activities should be carried out in the same two year cycle as community diagnosis.

The remaining sections of this report provide more specific details about the accountability system proposed by the Accountability Task Force. In these sections we describe an accountability tool, an accountability process, a proposal for an Office of Accountability and a means of integrating accountability measures into the public health system.

VI. LEVEL I: THE COMMUNITY WELLNESS INDEX (CWI)

The indicators which make up the CWI are intended to satisfy the following criteria:

1. they should, taken together, provide a fair view of the health status of a community;
2. each indicator should be a measure of a substantial public health problem, one that has a meaningful impact on community wellness;
3. indicators included in the CWI must be based on hard, county-specific data; no data based on synthetic estimates are to be allowed;
4. in virtually all instances, indicators are outcome measures.

In choosing the indicators which make up the CWI, we reviewed many references, among them the national Healthy People 2000 (HP 2000) objectives and the Healthy Carolinians 2000 (HC 2000) objectives. Because chronic diseases are such important contributors to morbidity and mortality, we chose to follow HP 2000 in including three separate chronic disease measures, rather than combining them as HC 2000 does. We also followed HP 2000 in making family planning a separate indicator. We included child health as a separate indicator although measures of child health are also found in other indicators. We also agreed to propose all the indicators which we feel belong in an ideal CWI; in those instances where insufficient county-specific data exist to include an indicator in the CWI at this time, it will be held out until data are sufficient to allow inclusion. These indicators will not take final form until input is received from the relevant liaison committees of the Association of Local Health Directors and other members of the public health community. We recognize that over time it will be possible to improve some of the Community Wellness Index measures; in particular, we feel there will be opportunities to improve the way we capture morbidity information.

Although in some instances the calculation used to generate an indicator may appear complex, the final result will be easy to understand: it will show the county's rank

within the state in that health status indicator. The components of the CWI and the associated indicators which we propose are as follows:

1. Maternal and Infant Health

   Z score[4] for infant mortality rate + Z score for low birthweight rate

2. Child Health

   Z score child mortality (all causes) + Z score childhood poverty (proportion of children less than 15 years of age living in families at or below poverty level)

3. Family Planning

   Z score of repeat pregnancies to teens + Z score of short birth interval pregnancies + Z score adolescent pregnancy rate (age 15-17)

4. Heart Disease and Stroke

   Z score age-adjusted mortality rate due to heart disease and stroke + Z score heart disease and stroke morbidity (as measured by hospital discharge)

5. Cancer

   Z score age adjusted mortality rate due to all cancers + Z score cancer morbidity (hospital discharge data)

6. Diabetes and Chronic Disabling Conditions

   Z score age adjusted mortality rate for diabetes and chronic disabling conditions + Z score for morbidity.

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[4] "Z" score refers to a statistical process which allows unlike rates to be combined as in a composite indicator. It creates a standard scale using standard deviations.

7. Injury

(25) (Z score motor vehicle injury rate) + (10) (Z score age 0-4 motor vehicle injury rate) + (15) (Z score homicide/assault rate) + (20) (Z score suicide rate) + (10) (Z score fall death rate, age greater than 65) + (5) (Z score fire/burns death rate) + (5) (Z score poisoning death rate) + (5) (Z score drowning death rate) + (5) (Z score other injury death rate)

8. Communicable Disease

(10) (Z score AIDS rate) + (20) (Z score Hepatitis B rate) + (10) (Z score TB rate) + (10) (Z score TB rate, ages 0-14) +(10) (Z score syphilis rate) + (5) (Z score congenital syphilis rate) +(10) (Z score perinatal HIV seroprevalence rate) + (15) (Z score shigella rate) + (5) (Z score pertussis rate) + (5) (Z score invasive Hib rate)

9. Immunization

0-75 points based on percent fully immunized at age 2 + 0-25 points based on percent of children fully immunized at school entry

10. Nutrition

Z score percent children who are obese [Health Services Information System (HSIS)] + Z score percent children who are underweight (HSIS) + Z score percent children who have stunted growth (HSIS) + Z score percent childbearing women with inappropriate prenatal weight gain (birth certificate data)

11. Environmental Health

12. Dental Health

(Number of people receiving optimal levels of systemic fluoride + number of school children receiving fluoride mouth rinse) divided by (total county population)

13. Tobacco, Alcohol and Other Drug Use

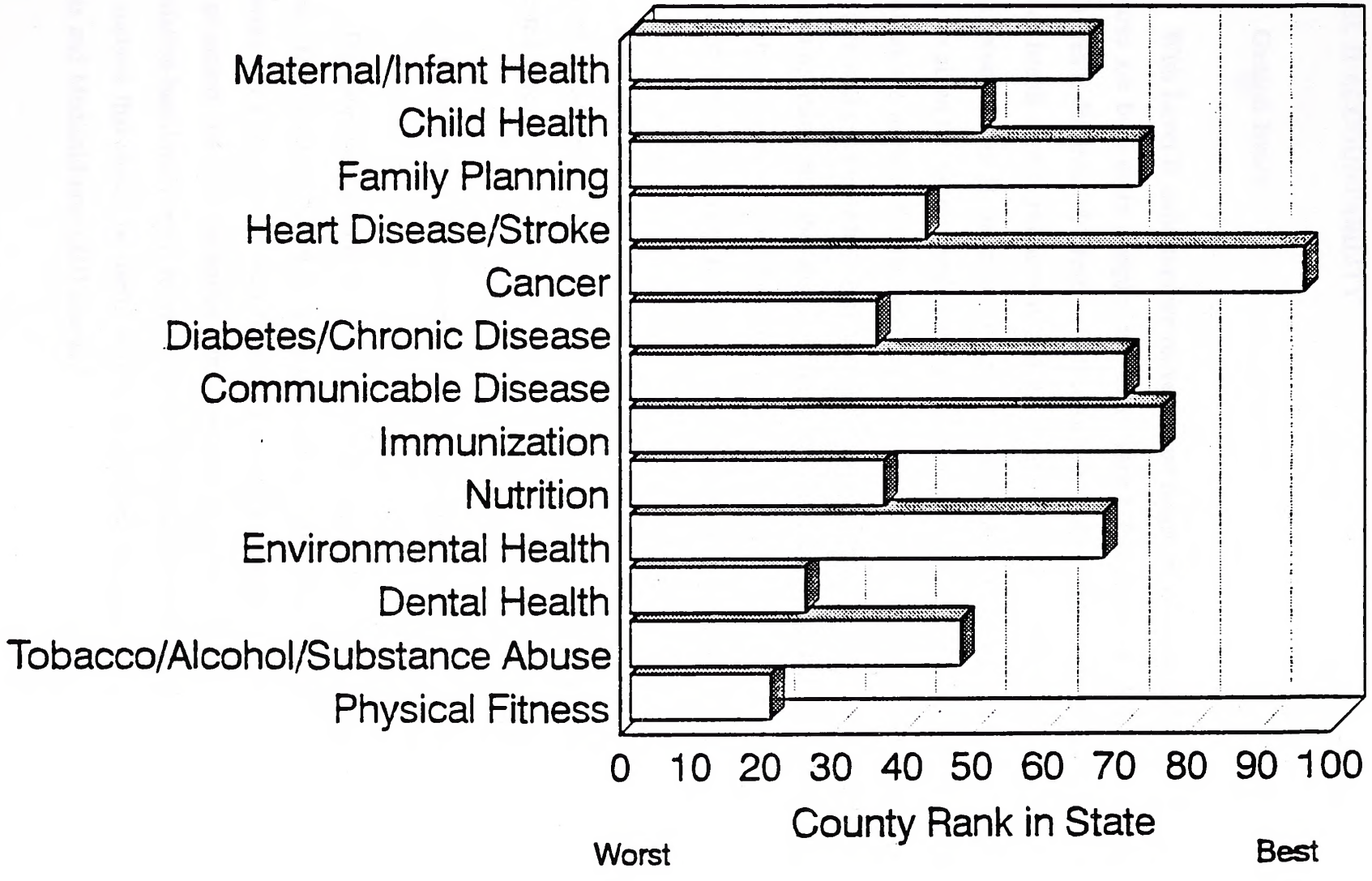
14. Physical Fitness

The Community Wellness Index is designed to provide members of the general public with meaningful and easily understood information about health status in their community. We feel it can be an important means of raising public awareness of public health issues, and for this reason we feel care should be taken in its graphic design and formatting to make it as visually appealing and user-friendly as possible. It should be a meaningful document to the general public, to members of the news media, to County Commissioners and to members of Boards of Health. In order to maximize its impact, we feel it should be issued by the State Health Director. The general form the CWI might take is shown on page 19.

Although we have focused on the Community Wellness Index as a means of delivering a sound bite of information about public health status, we recognize that it will also be important to supply supporting documentation about each indicator: what the public health significance of the indicator is, how the measure is calculated, how the indicator can be analyzed in greater depth, etc. This documentation should provide information which will allow each county to place its performance within the context of national or statewide goals (such as those in Healthy People 2000 or Healthy Carolinians 2000). We feel it is important that each county's health status in each indicator can be compared to state and national standards as well as to status in other counties.

Acme County Community Wellness Index

Health Status Indicator:



Удельный вес, %
0
20
40
60
80
100

VII. LEVEL II ACCOUNTABILITY

A. General Issues

With Level II indicators we move to true measures of accountability. These measures are both more complex and more varied than the Level I indicators. Each health area is different with respect to factors such as the nature of the available data, the level of health department activity and the level of state funding support. As a result, the proposed Level II indicators follow a variety of strategies to attempt to answer questions about the nature, quality and quantity of public health services being provided, as well as the impact of these services on health status (in instances where data allow some inferences to be made). Although different strategies are used, ATF members felt it was important that the major burden for data gathering fall primarily on the accountability system and secondarily on the health divisions; we felt that this should not be a labor-intensive activity for local health department personnel.

Because it is difficult to discuss the Level II indicators hypothetically, two types of Level II indicators, one largely data-driven and one primarily survey-based will be presented here.

B. A Level II Data-Driven Indicator: Maternal and Infant Health

The proposed Level II Maternal and Infant Health (MIH) indicator is largely data-driven. It is composed of four types of measures: 1) outcome measures, 2) process measures, 3) a measure of local financial participation and 4) sentinel event measures. The proposed outcome measures can generally be examined for the entire county (population-based measures), for the county's Medicaid population and for LHD clients. One analysis that should be useful will be to compare outcomes among Medicaid-LHD clients and Medicaid-non-LHD clients.

1. MIH Outcome Measures
    a. Mortality Measures
        i. Infant Mortality Rate (population based (PB), as well as Medicaid (M) population, including M-LHD and M-non-LHD).
            a. neonatal mortality rate
            b. postneonatal mortality rate
        ii. Birthweight-specific mortality rates (PB, M)
        iii. Fetal mortality ratios (PB)

In each of these instances, race-specific rates should also be generated. Consideration should be given to hospital-specific rates as well.

    b. Morbidity Measures
        i. Low birthweight rate (PB, M)
        ii. Very low birthweight rate (PB, M)
        iii. Small for gestational age rate (PB, M)
        iv. Severe complications of pregnancy (hospitalizations) (PB, M)
        v. HIV seroprevalence (PB)
        vi. Infant morbidity (Medicaid inpatient expenditures in first year of life per Medicaid infant) (M)
        vii. Percent of maternity patients with appropriate weight gain (PB, M).
        viii. Percent of mothers who breast feed

Once again, race-specific analysis should be done. Rates for Medicaid-LHD clients and for Medicaid-non-LHD patients should also be generated. Consideration should be given to generating hospital-specific rates.

2. MIH Process Measures
    a. Prenatal Care Measures
        i. late initiation of PNC (PB/M)

ii. adequacy of PNC utilization (Kotelchuck Index) (PB/M)

iii. waiting period to initiation of PNC (HD-specific)

b. Delivery of Comprehensive Care Measures

i. WIC and Supplemental Food

a. percent of WIC-eligible pregnant women enrolled

b. percent of WIC-eligible infants who received WIC

ii. Maternity Care Coordination

a. percent of MCC-eligible served

b. months of MCC provided/MCC eligible

iii. Continuity of Care

a. percent of women with live births who receive postpartum/family planning visit (M)

b. percent of infants who receive well-child care (M)

iv. Prenatal screening for detection of fetal abnormalities

percent of women in PNC who receive MSAFP screening

c. Delivery Measures

i. Risk-Appropriate Care: VLBW births in tertiary centers

percent VLBW births in tertiary centers - percent of all births in tertiary centers

ii. Cesarean Sections

- percent of Cesarean Section births
- VBAC ratio

percent of: vaginal birth after Cesarean/all repeat Cesareans

Consideration should also be given to assessing the percent of infants who received recommended well baby services at appropriate intervals (would need to use Medicaid population). With respect to cesarean section rates, hospital-specific rates should probably be developed. With respect to measures a., i-ii and b., iii, rates for Medicaid-LHD clients and Medicaid-non-LHD

clients should again be generated.

3. Local Financial Participation: Local Appropriation Per Ability to Pay

   This measure will follow the methodology of the Equity Committee to assess local participation in maternal health services, adjusting for ability to pay (adjustment based on county per capita income and county per capita assessed valuation). A county rank order would then be generated from this measure.

4. Sentinel Event Measures

   a. Maternal Mortality
   b. Pregnancies With No Prenatal Care
   c. Infant Mortality among normal birthweight infants without lethal congenital anomaly
   d. Infant Mortality Attributed to Injury
   e. Congenital Syphilis
   f. Congenital Rubella Syndrome
   g. Septic Abortion

The presence of a sentinel event indicates that a major breakdown in the service delivery system may have occurred. Sentinel events should be investigated to determine if systems intended to prevent their occurrence need to be revised.

5. Using the MIH Measures

   These indicators, taken together, should give a good picture of maternal and infant health status in a community. In addition, they provide a basis for an objective assessment of LHD MIH performance. The sentinel event measures used here alert us to areas where individuals may be "falling through the cracks," with major morbidity and mortality as a result. They sometimes alert us to deficiencies our other measures are unable to pinpoint. The measure of local financial participation provides

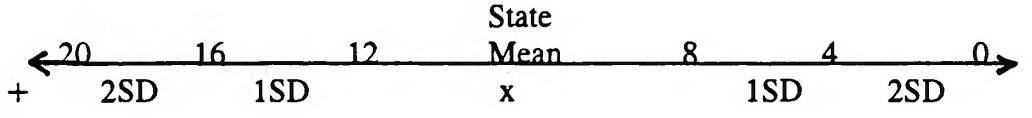
a measure of local commitment to supporting perinatal services. The process measures assess prenatal care utilization in the community. They also assess the extent to which interventions which have been demonstrated to improve birth outcomes and health status (WIC, MCC, family planning and well child care) are provided to clients in the community. The outcome measures used here provide key community-specific prenatal health status measures; they also begin to link birth outcomes to service providers.

C. A Level II Survey-Based Indicator: Communicable Disease

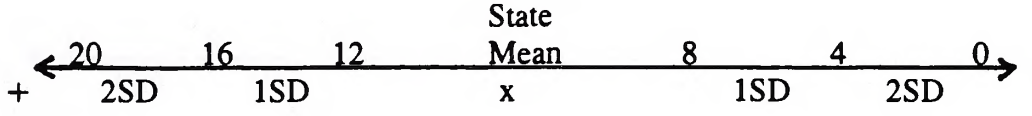
Other indicators will be primarily based on survey information, i.e. information obtained by questioning health department staff. The proposed Communicable Disease Level II indicator is of this variety. It is as follows:

Local health department progress in applying health outcome standards and achieving health outcome objectives. Scale: 0-200

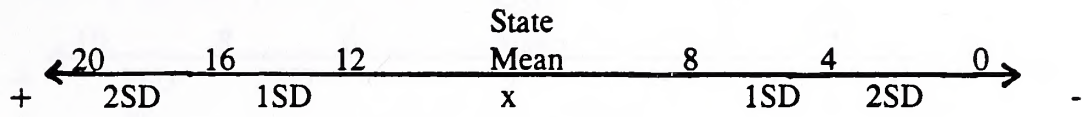
1. Percentage of household contacts of and infants born to known chronic hepatitis B carriers who completed prophylaxis within 9 months.



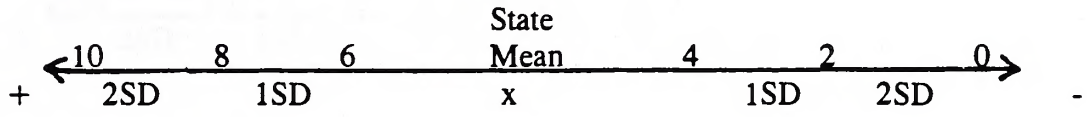
2. Percentage of hepatitis A and B cases reported that meet case definitions.



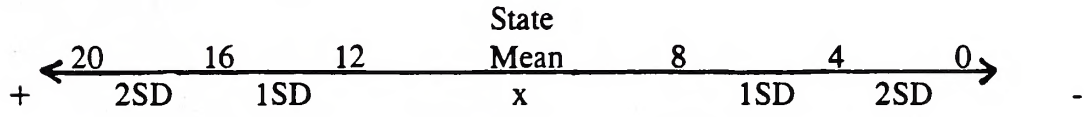
3. Percentage of persons tested for HIV who returned for results within 3 weeks.



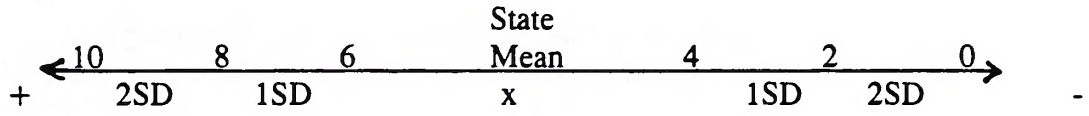
4. Percentage of staff providing STD service who are trained to conduct STD evaluations including physical examinations and laboratory work (gram stain, wet prep, urinalysis, stat RPR, and "stat" or "dry" darkfield) and who provide treatment under standing orders.



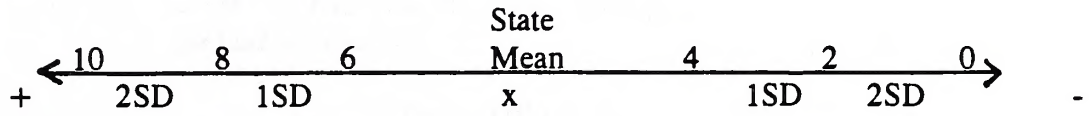
5. Percentage of persons requiring STD services seen and appropriately treated within 1 working day of request.



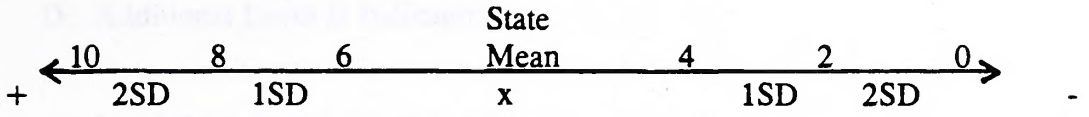
6. Percentage of TB cases who completed their treatment within 9 months.



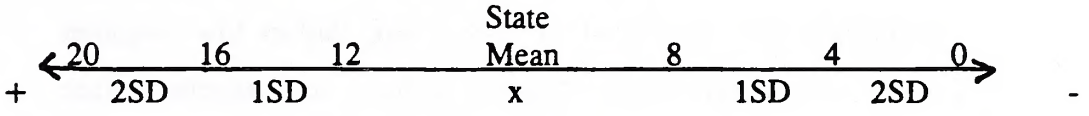
7. Percentage of TB cases on directly-observed therapy.



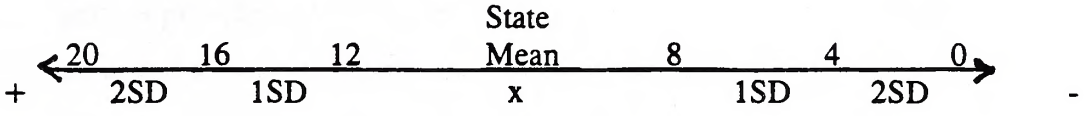
8. Percentage of persons eligible for (under American Thoracic Society Guidelines) TB preventive treatment who completed their treatment.



9. Proportion of outbreaks investigated and for which an outbreak report is filed with Communicable Disease Section within one month of outbreak occurrence.



10. Percentage of pregnant women who received syphilis tests in 1st and 3rd trimesters.



11. In the last 12 months, did the health department investigate all the cases of congenital syphilis and implement preventive strategies?

Yes (20 points)
No (0 points)

12. In the last 12 months, did the health department investigate all the cases of TB occurring in persons 0-14?

Yes (10 points)
No (0 points)

13. In the last 12 months, did the health department investigate all the cases of Hib disease cases among persons 0-4 and implement preventive strategies?

Yes (10 points)
No (0 points)

D. Additional Level II Indicators

In addition to the Level II indicators which have an associated Level I measure, the members of the Accountability Task Force identified two Level II indicators which have no Level I counterpart. The first, "Barriers to Service Provision," will measure local factors which may prevent a local health department from providing optimal care. Components of this indicator will include assessments of facility adequacy, adequacy of pay scales, adequacy of number of health department staff, amount of local appropriation (adjusted for ability to pay), adequacy of coalition building (utilization of community resources), adequacy of county provider pool (physician and mid-level providers per capita), and perhaps participation of private providers in public health interventions. Additional components will be added as they are identified. The second measure, "Administration and Supporting Services," will assess health department compliance with federal, state and local legislation and guidelines as they relate to a variety of administrative functions.

E. Three Final Points About Level II Indicators

The members of the Accountability Task Force were aware that these measures will not always be accurate indicators of poor health status in a community or deficient health department performance. They are intended to create a "rebuttable presumption"--to "red flag" an area as one where some evidence of a problem exists. It would then be the responsibility of the Office of Accountability and the relevant health division(s) to work with local representatives to determine if a real problem does exist. This process will be discussed more fully in Section VII.

The Level II indicators proposed by the task force should be modified based on input from the public health community. In particular, each liaison

committee of the Association of Local Health Directors will probably want to set aside some time to discuss indicators of interest to them with staff from the appropriate health divisions.

To come back to a point mentioned earlier in passing, if the Level II indicators function as intended, and do provide an accurate means of assessing health department performance in the area each indicator assesses, some Level III monitoring may be rendered redundant. Members of the task force feel that agencies which are superior performers in a given Level II indicator should be exempted from Level III monitoring in that area, excepting only those instances where the Level III monitoring is required to comply with federal or state legislation or rule.

VIII. THE ACCOUNTABILITY PROCESS

The members of the Accountability Task Force feel that the accountability system will operate effectively only if an Office of Accountability is created. This office should have lead responsibility for implementing, operating and fine-tuning the accountability system described in this report. The Office of Accountability should be lodged within the Office of the State Health Director. The head of the Office of Accountability must be an individual with standing in the public health community. It may be desirable to select an individual who has addressed accountability issues from both the statewide and the local perspective. The office should also include a statistician and secretarial support. The members of the task force recommend that the Office of Accountability be funded through reallocation of existing resources. In addition, up to $200,000 of Aid To County funds currently available to the Department should be set aside to help local health departments meet specific, negotiated, time-limited improvement plan objectives which arise from the accountability process.

Specific components of the accountability process and the role of the Office of Accountability in these activities are as follows:

- Level I accountability reports (CWI), as described above, will be prepared annually under the auspices of the Office of Accountability.

- The Level I report should be issued by the State Health Director.

- The Office of Accountability should have the capacity to respond to inquiries from local health departments and others about the interpretation and implications of the Level I report.
- The Office of Accountability should serve as a clearinghouse for Level I accountability related matters such as distribution of reports and related documents, marketing plans, speakers' bureau, etc.

- Level I data should be used to rank communities in ten percentile categories, i.e., those whose indicators place them in the top 10% through those whose indicators place them in the bottom 10%.

- All local health departments will be subject to Level II accountability assessment every two years; the accountability process will occur during approximately the same period as the Community Diagnosis process.

- Based on Level II data, surveys, and other approved information collection approaches, each division will rank all health departments in thirds (three gradients). Divisions will submit their rankings to the Office of Accountability. The Office will create an overall ranking of the departments in ten percentile categories.

- The Office of Accountability will work with county or district Board of Health members and local health department staff in counties which are in either the lowest Level I or Level II tenth percentile to develop an improvement plan for local health services. The improvement plan would be subject to review and approval by the local Board of Health. The Office will draw upon expertise from the divisions, other offices, and other sources to form teams to work with local health departments in developing improvement plans. The Office would be responsible for monitoring local health department progress and compliance with the improvement plans.

- In order to recognize outstanding communities and health departments, a Governor's Award for Excellence should be established. During each accountability cycle, the communities and health departments which are ranked by the Office of Accountability in the top 10% should be recognized with a Governor's Award for their special achievement.

- The Office of Accountability should take a pro-active role in conducting public affairs/communications about its role and responsibility in helping to improve public health service delivery.

- The Office of Accountability will have responsibility for incorporating new or revised indicators into the accountability process, but new indicators and revised indicators should arise from discussions between the relevant health division staff and members of the appropriate liaison committee. Consultation with the State Center should also be part of this process to help to ensure that indicators are both measurable and meaningful.

In recommending the formation of the Office of Accountability, the members of the Accountability Task Force recognize that the health divisions have an important role to play in assuring accountability at the statewide level. In order for the accountability system to operate optimally, the Office of Accountability must work cooperatively with the health divisions. The health divisions will always house the lion's share of State Health Department clinical and programmatic expertise relevant to each division's activities. The staff of the Office of Accountability will be generalists with respect to any particular public health program, but they will be specialists with respect to accountability. The importance of sharing these different types of expertise is clear.

The health divisions and the Office of Accountability will also need to work together if the contract addendum process is to be optimally utilized as a part of the accountability process. The contract addendum process offers a means of integrating the findings of the accountability process into the public health system: in instances where improvement plans are negotiated, improvement plan objectives can be incorporated into the contract addenda of the relevant programs. In this way, improvement plans can be translated into objectives which are part of a local agency's basic contractual obligations. In instances where the accountability system reveals problems within a specific program where the entire health department is not in the lowest tenth percentile, it is likely that

divisions will negotiate program-specific corrective action plans whose objectives can then be incorporated into contract addenda.

The members of the Accountability Task Force feel that with the implementation of a new accountability system, DEHNR should streamline the body of regulations which pertain to accountability. The department should review the "Standards for Mandated Public Health Services," and should prepare a recommendation to the Commission for Health Services that all standards not specifically determined to be relevant should be deleted. The members of the Task Force felt that the broad vision of public health services described in HB 499, "An Act to Establish the Mission and Essential Services of the Public Health System" and the "nuts and bolts" approach of the accountability system proposed in this report, taken together, form a good blend of a broad mission statement and a practical assessment process.

IX. HOW WE GET THERE: IMPLEMENTING THE ACCOUNTABILITY PROCESS

The Accountability Task Force has developed the following time line for implementing the accountability system proposed in this report.

January 6, 1994:	Last ATF meeting. Conclusion of review period for draft report. Consensus on final ATF report.
January 13:	Presentation of findings of ATF at State Health Director's Annual Meeting.
February 17:	ATF report reviewed at North Carolina Association of Local Health Directors meeting. Final ATF report available.
February 17-April 15:	Division of Maternal and Child Health and MCH Liaison Committee negotiate final Level I and Level II measures.
February 17-June 1:	Other divisions and liaison committees negotiate final Level I and Level II measures.
February 17-May 15:	Departmental review of accountability system proposed in ATF report, supplemented by additional information relating to the final form Level I and Level II indicators will take.
May 15, 1994:	DEHNR must submit MCH accountability system to Legislature; June 1 adopted by ATF as deadline for entire proposed accountability system.

Pilot Process

July 1, 1994: Office of Accountability up and running.

June-November: Level I indicators calculated for all counties.

Level II "data" indicators calculated either for volunteer pilot counties (approximately 5-6 counties) or for all counties; "survey" indicators compiled for volunteer counties.

Level I and II rankings compiled (approximately August 1 deadline for first version of Community Wellness Index--for internal use only).

Office of Accountability/health division teams visit selected pilot counties, generate corrective action plans, contract addenda revisions, etc.

Staff from pilot counties interviewed to assess strengths and weaknesses of process as piloted.

December: Revisions made to accountability process based on lessons of piloting process.

Revised Level I and Level II indicators submitted to Office of Accountability.

1995 Cycle

January-May, 1995: Data preparation for full round of accountability occurs (this time frame compatible with Community Diagnosis process); rankings generated.

May: Community Wellness Index information disseminated.

May:	Recommendation to Commission for Health Services concerning which components of "Model Standards" may be deleted.
June-August:	Office of Accountability/health division teams visit low ranking counties, discuss findings, begin to formulate corrective action plans, etc. as appropriate.

X. LOOKING TO THE FUTURE

One of the recurring themes of this report has been the idea that the accountability system should not be implemented as a static process but rather that it should evolve over time. Some improvements will result from the availability of better data. To cite one example, an earlier draft of this report proposed that information from the Medicaid cost-time study be incorporated into appropriate indicators as a cost/efficiency measure. Feedback led us to conclude that at this time these data are not a fair cost/efficiency measure, so this indicator was deleted. We remain committed to the idea that measures of cost and efficiency should be incorporated into the accountability process when fair and accurate measures of these parameters are available; the accountability system should be flexible enough to include such data when they are available. Other improvements will result from lessons learned from piloting the accountability process. The members of the Accountability Task Force feel it is quite likely that the accountability system of five or ten years hence will be different in a number of ways from the one proposed here.

The accountability system proposed in this report has as its ultimate goal the assurance of quality in the delivery of health services in the public sector. The goals of accountability and quality assurance are relevant to the private sector as well as the public sector; this is another way in which the accountability system of the future may differ from the one proposed here. In the context of health care reform, accountability in both the public and private sectors is more important than ever before. In any health care reform, objective data about service provision and health outcomes are essential. Whose role will it be to provide consumers with this information?

There is a good argument to be made that a core function of state health departments of the future will be to administer accountability processes that assess health care delivery (both quantity and quality) and health status for all residents of the state, without distinction with respect to "public sector" or "private sector." The accountability system described in this report provides a good starting point for the design of such a comprehensive system.

10 NCAC 12 .0228 through .0242 have been adopted as follows:

.0228 GENERAL

(a) The Rules of this Section establish a list of mandated public health services for local health departments and establish standards for each service. The rules also establish a standard for quality assurance which applies to all mandated services. The rules were developed to ensure that certain basic public health services would be available to citizens throughout the State, and that these mandated services meet reasonable standards governing quality, availability, and accessibility.

(b) Each local health department will be assessed for compliance with the Rules of this Section by a regional director every four years. The regional liaison health director or another local health director designated by the North Carolina Association of Local Health Directors may accompany the regional director in the assessment.

(c) Upon completion of each assessment, the regional director will prepare a report of the findings. The report will then be submitted to the State Health Director who will share the report with the appropriate section chiefs.

(d) Based upon the standards assessment report, section chiefs will direct regional staff to visit the local health department in order to negotiate a plan of corrective action to achieve compliance with these Rules. Section chiefs will also direct regional staff to heighten technical assistance to those local health departments working on a corrective action plan.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0229 QUALITY ASSURANCE

A local health department shall establish, implement, and maintain written policies to assure quality in all administrative, environmental, clinical, and educational services and activities mandated by the Commission which are contracted for or provided by the local health department. Policies shall include:

(1) Provisions for a periodic program assessment to be conducted at least once per year which shall include:
   (a) A review of appropriate clinical and non-clinical records.
   (b) Development of a corrective action time-table for making necessary improvements.
   (c) Representation in the quality assurance program of each discipline involved in service provision.
   (d) A review of appropriate state or local reports and statistics.
   (e) Documentation of review findings.
   (f) Documentation of corrective action.
(2) Provisions for staff development and training opportunities.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0230 CHILD HEALTH

(a) A local health department shall provide, contract for the provision of, or certify the availability of child health services for all individuals within the jurisdiction of the local health department. A local health department

shall establish, implement, and maintain written policies which shall include:

(1) A description of the procedures for child health services provided by the local health department, a copy of the contract for the provision of child health services, or a certification of availability of child health services. These child health services shall include:

(A) Child health information, referral, immunizations, and hemoglobinopathy screening upon request.

(B) Identification and follow-up of high priority infants.

(C) Follow-up of infants with PKU or hypothyroidism.

(D) Follow-up of chronically ill and handicapped infants and children upon request.

(E) Routine periodic well-child supervision to children less than six years of age, not served by another health care resource, through one or more of the following mechanisms:

(i) Referral to other health care providers;

(ii) contracts with other health care providers; or

(iii) provision of the following health assessment services in a local health department child health clinic:

(I) Initial and interim health history;

(II) physical assessment and laboratory services;

(III) developmental evaluation;

(IV) nutrition assessment;

(V) counseling, including anticipatory guidance; and

(VI) referral for further diagnosis and treatment.

(2) A description of the target population for child health services provided by the local health department, including eligibility criteria. The local health department shall emphasize provision of child health services to individuals who would not otherwise have access to these services.

(3) A description of fees, if any, for child health services provided by the local health department.

(b) A local health department shall establish, implement, and maintain written policies for the provision of community and patient child health education services within the jurisdiction of the local health department. The policies shall include a description of the procedures for provision of services for identification of, recruitment of, and outreach to the target population.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0231 MATERNAL HEALTH

(a) A local health department shall provide, contract for the provision of, or certify the availability of maternal health services for all individuals within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) A description of the procedures for maternal health services provided by the local health department, a copy of the contract for the provision of maternal health services, or a certification of availability of maternal health services. These maternal health

services shall include:

(A) Pregnancy testing, information, and referral as appropriate;

(B) Ongoing prenatal care to all pregnant women, not served by another health care resource, through one or more of the following mechanisms:

(i) Referral to other health care providers;

(ii) contracts with other health care providers; or

(iii) provision of the following prenatal services in a local health department maternity clinic:

(I) Initial history, and physical and laboratory examinations;

(II) assessment of medical, nutritional, and social problems;

(III) weekly assessments by a physician or a registered nurse, as medically indicated.

(IV) laboratory, nutrition, and patient education follow-up services;

(V) high-risk identification and referral; and

(VI) scheduling of postpartum visits.

(2) A description of the target population for maternal health services provided by the local health department, including eligibility criteria. The local health department shall emphasize provision of maternal health services to individuals who would not otherwise have access to these services.

(3) A description of fees, if any, for maternal health services provided by the local health department.

(b) A local health department shall establish, implement, and maintain written policies for the provision of community and patient maternal health education services within the jurisdiction of the local health department. Education services shall promote healthy lifestyles for good pregnancy outcome.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0232 FAMILY PLANNING

(a) A local health department shall provide, contract for the provision of, or certify the availability of family planning services for all individuals within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) A description of the procedures for family planning services provided by the local health department, a copy of the contract for the provision of family planning services, or a certification of availability of family planning services. These family planning services shall include:

(A) Patient history assessments;

(B) Physical examinations and laboratory services;

(C) Medical, nutritional, and social assessments;

(D) Provision of contraceptive information and the use of informed consent procedures when prescribing a method of contraception;

(E) Treatment, referral, and follow-up.

(2) A description of the target population for family planning services provided by the local health department, including eligibility criteria. The local health department shall emphasize provision of

family planning services to individuals who would not otherwise have access to contraceptive services in the community.

(3) A description of fees, if any, for family planning services provided by the local health department.

(b) A local health department shall establish, implement, and maintain written policies for the provision of community and client family planning education services within the jurisdiction of the local health department. The policies shall include a description of the procedures for provision of services for identification of, recruitment of, and outreach to the target population.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0233 DENTAL PUBLIC HEALTH

(a) A local health department shall provide, contract for the provision of, or certify the availability of dental public health services for all individuals within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) A description of the procedures for dental public health services provided by the local health department, a copy of a contract for the provision of dental public health services, or a certification of availability of dental public health services. These dental public health services shall include:

(A) Individual preventive dental health services for school children (k-12), including flouride mouthrinse services and individual plaque control services.

(B) Dental screening and referral services, including emergency referral services for school children (k-12).

(C) Cooperation with the Division in promoting and obtaining flouridation of community and school water systems, including keeping records of all water systems within the jurisdiction of the local health department which are flouridated.

(2) A description of the target population for dental public health services, provided by the local health department, including eligibility criteria.

(3) A description of fees, if any, for dental public health clinical treatment services provided by the local health department.

(b) A local health department shall establish, implement, and maintain written policies for the provision of community and client dental public health education services within the jurisdiction of the local health department.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0234 HOME HEALTH

(a) A local health department shall provide, contract for the provision of, or certify the availability of home health services for all individuals within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) A description of the home health services provided by the local health

department, a copy of the contract for the provision of home health services, or a certification of availability of home health services.

(2) A description of fees for home health services provided by the local health department.

(b) A local health department which provides home health services shall meet the standards for licensure of home health agencies found in 10 NCAC 3L found in 42 CFR 45 .1201.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0235 ADULT HEALTH

(a) A local health department shall provide, contract for the provision of, or certify the availability of adult health services for all individuals within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) A description of the procedures for adult health services provided by the local health department, a copy of the contract for the provision of adult health services, or a certification of availability of adult health services. These shall include the following prevention and detection services for cancer, diabetes, and hypertension.

(A) Identification, recruitment, screening, including laboratory services, referral, and follow-up;

(B) Nutrition services to patients and persons at risk.

(2) A description of the target population for adult helth services provided by the local health department, including eligibility criteria.

(3) A description of fees, if any, for adult health services provided by the local health department.

(b) A local health department shall establish, implement, and maintain written policies for the provision of cancer, diabetes, and hypertension health education services to the community, persons at risk, and patients.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0236 INDIVIDUAL (ON-SITE) WATER SUPPLY

(a) A local health department shall provide individual (on-site) water supply sanitation services within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) Provisions for inspecting individual water supplies upon request and identifying needed improvements. When indicated, water samples are collected for bacteriological or chemical analysis in an approved manner, and the samples are submitted to a certified lab for analysis.

(2) Provisions for investigating complaints and suspected outbreaks of illness associated with water supplies. Corrective actions shall be taken in cases of valid complaints and confirmed outbreaks of illness.

(3) Provisions for keeping records of activities described in paragraphs (1) and (2).

(b) A local health department shall establish, implement, and maintain written policies for the provision of orientation and in-service training for

sanitarians. The policies shall include the following minimum requirements for sanitarians providing individual on-site water supply services:

(1) Initial field training for newly employed sanitarians;
(2) CDC Homestudy Course 3010-G or its equivalent as approved by the Division;
(3) North Carolina State University Food Protection Short Course or its equivalent as approved by the Division; and
(4) Registration by the Board of Sanitarian Examiners.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0237 SANITARY SEWAGE COLLECTION, TREATMENT, AND DISPOSAL

(a) A local health department shall regulate sewage collection, treatment, and disposal within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) Provisions for the enforcement of permit requirements specified in the sewage law and rules.
(2) Provisions for investigating complaints and suspected outbreaks of illness associated with sewage collection, treatment, and disposal. Corrective actions shall be taken in cases of valid complaints and confirmed outbreaks of illness.
(3) Provisions for keeping records of activities described in paragraphs (1) and (2) of this Rule.

(b) A local health department shall establish, implement, and maintain written policies for the provision of orientation and in-service training for sanitarians. The policies shall include the following minimum requirements for sanitarians providing sanitary sewage collection, treatment, and disposal services:

(1) Initial field training for newly employed sanitarians;
(2) CDC Homestudy Course 3010-G or its equivalent as approved by the Division;
(3) Sanitation Branch Soils Workshop; and
(4) Registration by the Board of Sanitarian Examiners.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0238 GRADE "A" MILK SANITATION

(a) A local health department shall provide or certify the availability of grade "A" milk sanitation services within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) When applicable, the frequency of inspections for grade "A" milk sanitation activities, with the following being the minimum:

Type of Activity	Frequency
Bulk milk tank trucks	1/year
Commingled raw milk samples (plant origin)	4/six months

Cooling water samples	1/six months
Dairy farm inspections	1/six months
Farm well water samples	1/three years or sampled when repaired
Hauler certifications	1/two years
Individual producer raw milk samples (farm origin)	4/six months
Pasteurized milk samples	Each product 4/six months
Pasteurization plant equipment tests	1/three months
Pasteurization plant inspections	1/three months
Temperature checks and inspection of retail storage facilities	During each sanitation inspection of restaurants, meat markets, etc.

(2) Provision for laboratoy analysis by a certified milk analyst.

(3) Provisions for investigating complaints and suspected outbreaks of illness associated with milk and milk products. Corrective actions shall be taken in cases of valid complaints and confirmed outbreaks of illness.

(4) Provisions for keeping records of activities described in paragraphs (1) and (2).

(b) A local health department shall establish, implement, and maintain written policies for the provision of orientation and in-service training for sanitarians. The policies shall include:

(1) The following minimum requirements for milk sanitarians:

(A) Initial field training for newly employed sanitarians;

(B) CDC Homestudy Course 3010-G or its equivalent as approved by the Division;

(C) North Carolina State University Food Protection Short Course or its equivalent as approved by the Division; and

(D) Registration by the Board of Sanitarian Examiners.

(2) Provisions for counties which carry out milk plant inspection activities to have representation at the FDA Course 302, "Milk Pasteurization Controls and Tests", when it is offered within the state. Counties which carry out dairy farm inspection activities shall have representation at each North Carolina State University "Dairy Fieldman and Sanitarians Conference".

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0239 FOOD, LODGING, AND INSTITUTIONAL SANITATION

(a) A local health department shall provide food, lodging, and institutional sanitation services within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) The frequency of inspections of food, lodging, and institutional facilities with the following being the minimum:

Type of Establishment	Frequency
Bed and breakfast homes	1/year
Child day-care facilities	1/year
Educational food service	3/year
Institutions	2/year
Local confinement facilities	1/year
Lodging	2/year
Mass gatherings	2/gathering
Meat markets	4/year
Migrant housing	2/year
Mobile food units	4/year
Private boarding schools and colleges	2/year
Pushcarts	4/year
Residential care facilities	1/year
Restaurants	4/year
School lunchrooms	3/year
Schools	1/year
Seasonal establishments (operate 3 months or less/year)	1/year
Summer camps	1/year
Temporary restaurants, food stands, or drink stands	1/two weeks
Vending machine locations	Representative number of locations/ year

(2) Provisions for investigating complaints and suspected outbreaks of illness associated with food, lodging, and institutional facilities. Corrective actions shall be taken in cases of valid complaints and confirmed outbreaks of illness.

(3) Provisions for keeping records of activities described in paragraphs (1) and (2).

(b) A local health department shall establish, implement, and maintain written policies for the provision of sanitation education for food service personnel and orientation and in-service training for sanitarians. The policies shall include the following minimum requirements for sanitarians providing food, lodging, and institutional sanitation services:

(1) Initial field training for newly employed sanitarians;

(2) CDC Homestudy Course 3010-G or its equivalent as approved by the Division;

(3) North Carolina State University Food Protection Short Course or its equivalent as approved by the Division; and

(4) Compliance with the Board of Sanitarian Examiners' requirements.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0240 COMMUNICABLE DISEASE CONTROL

(a) A local health department shall provide services and perform activities for the control of communicable disease within the jurisdiction of the local

health department. A local health department shall establish, implement, and maintain written policies which shall include a description of the procedures for communicable disease control services and activities provided by the local health department which shall include:

(1) GENERAL COMMUNICABLE DISEASE CONTROL:

(A) Reporting communicable diseases as required by law. Additionally, cases of vaccine-preventable diseases shall be reported to the designated Division program representative within 24 hours of receipt of the report.

(B) Investigating any outbreaks of a reportable communicable disease within the jurisdiction of the local health department to determine the cause(s) of the outbreak and to ensure that appropriate steps are taken to arrest the outbreak and prevent its recurrence.

(C) Investigating each case of a communicable disease for which there is a surveillance form supplied by the Division of Health Services. Forms shall be completed and submitted to the Division.

(D) Distributing communicable disease report cards with instructions for submission to all pediatricians, internists, and family/general practitioners practicing within the jurisdiction of the local health department.

(2) TUBERCULOSIS CONTROL:

(A) Tuberculosis diagnostic and follow-up services for cases, contacts, and suspects which include:

(i) Medical and epidemiological history;

(ii) Assessment of blood pressure, weight, urinalysis, if indicated, and visual acuity and color discrimination, if indicated;

(iii) Special investigations, such as Mantoux skin test, chest x- ray, mycobacteriology, and other investigations as indicated.

(B) Tuberculosis treatment services which include:

(i) Provision of anti-tuberculosis drugs as medically prescribed;

(ii) Monthly monitoring of intake and for adverse side effects of anti-tuberculosis drugs by office visit, home visit, or telephone;

(iii) Coordination and communication with private medical providers.

(3) IMMUNIZATION:

(A) Providing resources to ensure that all children within the jurisdiction of the local health department receive all vaccines required by law within the time frames established by law.

(B) Providing vaccines in clinics, with at least one each month accessible to working parents.

(C) Enforcing the immunization law pertaining to day-care facilities, including submitting the immunization records audit form.

(D) Assisting local school officials in enforcing the immunization law pertaining to public and private schools (k-12).

(E) Ensuring accountability for all doses of vaccine provided by the Division.

(4) VENEREAL DISEASE CONTROL:

(A) Diagnostic testing and examination services for syphilis and gonorrhea shall be available each weekday;

(B) Treatment services, both therapeutic and preventive, for reportable venereal disease shall be available each weekday;

(C) Counseling and education designed to influence disease intervention and prevention behaviors, particularly that designed to enlist

patient cooperation in referring sex partners for examination and treatment, shall be available each weekday;

(D) follow-up and referral of persons with positive venereal disease laboratory tests shall be available each weekday.

(b) A local health department shall establish, implement, and maintain written policies for the provision of communicable disease control education services to the community, health care personnel, and patients. The services shall include provision of clinic schedules, information on communicable disease reporting, and other communicable disease control information to local medical organizations, veterinarians, animal control officers, health care providers, and the media, as appropriate.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0241 VITAL RECORDS

(a) A local health department shall provide vital records services within the jurisdiction of the local health department. The local health director shall serve as the local registrar and shall perform the duties of that office as prescribed by law. A local health department shall establish, implement, and maintain written policies which shall include:

(1) Procedures for reporting flagrant, willful violations of the vital records law and reporting known vital events for which a certificate has not been obtained.

(2) A file of all vital records laws, rules, and instructions issued by the state registrar.

(3) Procedures for the examination of birth, death, and fetal death certificates for accuracy and completeness.

(4) Procedures for returning incomplete or inaccurate certificates to or querying the persons responsible for filing them for completion and correction.

(b) A local health department shall establish, implement, and maintain written policies for obtaining vital records education services from the State Registrar's Office for local registration personnel, hospital administrators, and their medical records personnel, funeral directors, medical examiners, and others involved in the registration system. The policies shall include provisions for orientation of new deputy registrars, subregistrars, and back-up health department personnel.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

.0242 LABORATORY

A local health department shall provide, contract for the provision of, or certify the availability of public health laboratory services appropriate to the activities of the department for all individuals within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include:

(1) A description of the public health laboratory services provided by the local health department, a copy of a contract for the provision of public health laboratory services, or a certification of availability of public health laboratory services. These public health laboratory

services shall include:

(a) Clinical tests to aid in the diagnosis and treatment of diseases and conditions.
(b) Clinical tests to monitor the response to treatment.
(c) Clinical tests to screen for asymptomatic diseases and conditions.
(d) Analyses required for environmental activities of the local health department.

(2) An identification of one person to manage the laboratory services program.
(3) A description of fees, if any, for public health laboratory services provided by the local health department.
(4) A standard operating procedures manual which contains standardized protocols and describes quality control requirements for all procedures performed by the local health department.
(5) An assurance that persons performing tests and analyses have demonstrable skill and competence in achieving accuracy and precision of tests and analyses.
(6) Provisions for adequate space and facilities.
(7) A description of the laboratory records system. The system shall include documentation of quality control.
(8) Provisions for the protection of the safety of staff, patients, clients, and the general public regarding specimen collection, laboratory operations, and disposal of wastes.
(9) A description of eligibility criteria, if any, for public health laboratory services provided by the local health department.

History Note: Statutory Authority G.S. 130A-9;
Eff. October 1, 1984.

GENERAL ASSEMBLY OF NORTH CAROLINA
1991 SESSION
RATIFIED BILL

CHAPTER 299
HOUSE BILL 499

AN ACT TO ESTABLISH THE MISSION AND ESSENTIAL SERVICES OF THE PUBLIC HEALTH SYSTEM.

The General Assembly of North Carolina enacts:

Section 1. Article 1 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"§ 130A-1.1. Mission and essential services.

(a) The General Assembly recognizes that unified purpose and direction of the public health system is necessary to assure that all citizens in the State have equal access to essential public health services. The General Assembly declares that the mission of the public health system is to promote and contribute to the highest level of health possible for the people of North Carolina by:

(1) Preventing health risks and disease;
(2) Identifying and reducing health risks in the community;
(3) Detecting, investigating, and preventing the spread of disease;
(4) Promoting healthy lifestyles;
(5) Promoting a safe and healthful environment;
(6) Promoting the availability and accessibility of quality health care services through the private sector; and
(7) Providing quality health care services when not otherwise available.

(b) As used in this section, the term 'essential public health services' means those services that the State shall assure because they are essential to promoting and contributing to the highest level of health possible for the citizens of North Carolina. The Department of Environment, Health, and Natural Resources shall attempt to assure within the resources available to it that the following essential public health services are available and accessible to all citizens of the State, and shall account for the financing of these services:

(1) Health Support:
  a. Assessment of health status, health needs, and environmental risks to health;
  b. Patient and community education;
  c. Public health laboratory;
  d. Registration of vital events;
(2) Environmental Health:
  a. Lodging and institutional sanitation;
  b. On-site domestic sewage disposal;
  c. Water and food safety and sanitation; and
(3) Personal Health:
  a. Child health;

b. Chronic disease control;
c. Communicable disease control;
d. Dental public health;
e. Family planning;
f. Health promotion and risk reduction;
g. Maternal health.

The Commission for Health Services shall determine specific services to be provided under each of the essential public health services categories listed above.

(c) The General Assembly recognizes that there are health-related services currently provided by State and local government and the private sector that are important to maintaining a healthy social and ecological environment but that are not included on the list of essential public health services required under this section. Omission of these services from the list of essential public health services shall not be construed as an intent to prohibit or decrease their availability. Rather, such omission means only that the omitted services may be more appropriately assured by government agencies or private entities other than the public health system.

(d) The list of essential public health services required by this section shall not be construed to limit or restrict the powers and duties of the Commission for Health Services or the Department of Environment, Health, and Natural Resources as otherwise conferred by State law."

Sec. 2. This act becomes effective October 1, 1991.

In the General Assembly read three times and ratified this the 17th day of June, 1991.

JAMES C. GARDNER

James C. Gardner
President of the Senate

DANIEL BLUE, JR.

Daniel Blue, Jr.
Speaker of the House of Representatives

GENERAL ASSEMBLY OF NORTH CAROLINA
1991 SESSION
RATIFIED BILL

CHAPTER 548
HOUSE BILL 183

AN ACT TO REQUIRE THE DEPARTMENT OF ENVIRONMENT, HEALTH, AND NATURAL RESOURCES TO CONDUCT VARIOUS HEALTH-RELATED PROJECTS.

The General Assembly of North Carolina enacts:

Section 1. (a) The Department of Environment, Health, and Natural Resources shall do the following to improve the State public health system:

(1) Develop and conduct activities designed to expand the Department's capability and the capability of local health departments or districts to secure private sector financial resources to supplement public health activities and services mandated by the State.

(2) Develop a plan for the establishment of a statewide system for assessing health status and health needs in every county. In determining community health status and needs, the Department shall solicit and consider input from private providers, community groups and agencies, the general public, and policy makers.

(3) Plan for the development and implementation of a computerized statewide data collection and retrieval system that will permit comparisons of health data and indices, and that will enable local health departments to have access to data collected. In developing the plan the Department shall consider recommendations in the 1989-90 Public Health Study Commission's final report pertaining to standardization, adaptability, and costs of integrating local data collection systems with the State system.

(4) Implement a monitoring and evaluation program to measure local health department progress in applying health outcome standards and achieving health outcome objectives established by the Commission for Health Services under G.S. 130A-29(c)(7). The Department shall conduct monitoring and evaluation on a regularly scheduled basis, and shall provide assistance to local health departments that are having difficulty meeting objectives.

(b) The Department of Environment, Health, and Natural Resources shall report to the North Carolina Public Health Study Commission, if the Commission is established by the General Assembly, on the status of each project in subsection (a) of this section. The Department shall report to the Commission at the Commission's request. If the General Assembly does not establish the North Carolina Study Commission on Public Health, then the Department shall report the status of the project activity required under subsection (a) to the Joint Legislative Commission on Governmental Operations in March, 1992.

Sec. 2. G.S. 130A-29 reads as rewritten:

"**§ 130A-29. Commission for Health Services -- creation, powers and duties.**

(a) The Commission for Health Services is created with the authority and duty to adopt rules to protect and promote the public health.

(b) The Commission is authorized to adopt rules necessary to implement the public health programs administered by the Department as provided in this Chapter.

(c) The Commission shall adopt rules:

(1) Repealed by Session Laws 1983 (Regular Session, 1984), c. 1022, s. 5.

(2) Establishing standards for approving sewage-treatment devices and holding tanks for marine toilets as provided in G.S. 75A-6(o);

(3) Establishing specifications for sanitary privies for schools where water-carried sewage facilities are unavailable as provided in G.S. 115C-522;

(4) Establishing requirements for the sanitation of local confinement facilities as provided in Part 2 of Article 10 of Chapter 153A of the General Statutes; ~~and~~

(5) Repealed by Session Laws 1989 (Regular Session, 1990), c. 1075, s. 1, effective July 28, 1990.

(6) Requiring proper treatment and disposal of sewage and other waste from chemical and portable ~~toilets.~~ toilets; and

(7) Establishing statewide health outcome objectives and delivery standards.

(d) The Commission is authorized to create:

(1) Metropolitan water districts as provided in G.S. 162A-33;

(2) Sanitary districts as provided in Part 2 of Article 2 of this Chapter; and

(3) Mosquito control districts as provided in Part 2 of Article 12 of this Chapter.

(e) Rules adopted by the Commission for Health Services shall be enforced by the Department of Environment, Health, and Natural Resources."

Sec. 3. This act is effective upon ratification.

In the General Assembly read three times and ratified this the 4th day of July, 1991.

HENSON P. BARNES

~~James C. Gardner~~ HENSON P. BARNES
President of the Senate PRO TEMPORE

DANIEL BLUE, JR

Daniel Blue, Jr.
Speaker of the House of Representatives

(b) The Department of Environment, Health, and Natural Resources shall prepare a plan to ensure that local health departments are providing or arranging for the services necessary to meet the health care needs of pregnant women, infants, and children under age five. The plan shall include a description of rules, policies, and procedures, and any changes in State law, necessary to:

(1) Identify counties in which excessive infant and child morbidity and mortality exist;

(2) Provide local health departments in these identified counties with assistance in developing and implementing improvement plans; and

(3) Ensure that these local health departments meet appropriate improvement goals.

In order to ensure that improvement goals are met, the Department's plan shall include a compliance system. The compliance system may include: heightened technical assistance; targeting of additional resources; withholding of federal or State funds; administrative changes, including formation of district health departments where appropriate; the appointment of caretaker administrators or public health boards; or any other measure necessary to ensure that the health care needs of pregnant women, infants, and children under age five are being met.

The Department of Environment, Health, and Natural Resources, Division of Maternal and Child Health, shall submit this report to the General Assembly no later than May 15, 1994.

(c) Of the funds appropriated in this act from the General Fund to the Department of Environment, Health, and Natural Resources, Division of Maternal and Child Health, the sum of three hundred seventy-five thousand dollars ($375,000) for the 1993-94 fiscal year and the sum of seven hundred fifty thousand dollars ($750,000) for the 1994-95 fiscal year shall be used to expand the existing Comprehensive Adolescent Health Projects. Ten additional grants will be available to be awarded each year of the biennium. To receive funding, each project must arrange for or provide preventive and primary medical care and mental health services, including, but not limited to: preventive services to delay early sexual involvement, treatment of minor problems and injuries, referrals and follow-up treatments for serious illnesses and injuries, referrals for alcohol and other drug abuse, sexually transmitted diseases, and immunizations. The Comprehensive Adolescent Health Care Projects shall be developed with the participation of the public schools, local health departments, area mental health programs, community migrant and rural health centers, private physicians, and other appropriate community programs.

Requested by: Representatives Easterling, Diamont, Bowman, DeVane, H. Hunter, Luebke, Senators Martin of Pitt, Cochrane

CHILD FATALITY PREVENTION SYSTEM

Sec. 285. (a) Article 62 of Chapter 143 of the General Statutes reads as rewritten:

"ARTICLE 62.

"North Carolina Child Fatality ~~Review Team; North Carolina Child Fatality Task Force and Study.~~ Prevention System.

"§ 143-571. Declaration of public policy.

The General Assembly finds that it is the public policy of this State to prevent the abuse and neglect of children and child deaths. The General Assembly further finds that the prevention of the abuse and neglect of children and child deaths is a community responsibility; that professionals from disparate disciplines have responsibilities for children and have expertise that can promote child safety and well-being; and that multidisciplinary reviews of the abuse and neglect of children

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